



Minnesota Department of Health

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Accra Home Health Duluth			Report Number: H8002003	Date of Visit: February 11, 2016
Facility Address: 5322 Grand Avenue			Time of Visit: Phone investigation	Date Concluded: February 2, 2017
Facility City: Duluth			Investigator's Name and Title: Jill Hagen, R.N., Special Investigator	
State: Minnesota	ZIP: 55807	County: Saint Louis		

HHA

Allegation(s):

It is alleged that a client was financially exploited when the alleged perpetrator (AP) took an envelope full of money out of the client's walker.

- Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, financial exploitation occurred when the AP took an envelope containing the client's money, without the client's knowledge.

The home health agency provided homemaking services, including transportation for the client to shop. The client managed his/her own finances and used a walker to assist with ambulation.

During an interview, the client established the day of the money went missing was the first time the AP provided services for the client. The AP drove the client to a local drug store. The client had an envelope that contained cash to pay for his/her purchases - which totaled about \$27.00 - leaving an unknown amount of money in the envelope. The client placed the envelope in a bag attached to the walker. The AP assisted the client into his/her apartment leaving the walker in the hallway. After the AP left, the client remembered the envelope with the cash in the bag attached to the walker. The client checked the bag and the envelope was gone. The client called the drug store and the stores security tape showed the client putting the envelope in bag attached to the walker. The client contacted the care taker of the apartment building. A camera located in the hallway pointed toward the client's apartment captured the AP removing the envelope from the bag and placing the envelope in the AP's coat pocket. The client contacted the local police who investigated the allegation. The client said the police returned the envelope after the AP returned the envelope to the home health agency. The envelope contained \$53.00.

During an interview, a manager of the agency established s/he was notified by the police of the alleged

financial exploitation. The AP contacted the home health agency after the AP had been contacted by the police. The AP said she discovered the envelope in the backseat of his/her car the following day, and the envelope must have fallen out of the client's bag attached to the walker. Management staff told the AP video from the client's hallway showed the AP removing the envelope from the client's walker and placing the envelope in his/her coat pocket. The AP brought a sealed envelope to the home health agency indicating it contained the client's money. The agency returned the money to police without opening the envelope.

During an interview, the AP denied taking the money from the client, stating the envelope must have fallen out of the bag attached to the client's walker during the drive. The client sat in the passenger side of the car and the AP placed the walker in the backseat behind the client. The AP said she found the envelope the following day after being contacted by the police. The AP said s/he was checking on the client's shoes when she touched the bag in the hallway. The AP denied taking the envelope with the money.

A police report established the AP removed the client's white envelope from the bag and put that envelope in the AP's coat pocket.

The AP was terminated from employment at the home health agency.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

- Abuse
- Neglect
- Financial Exploitation
- Substantiated
- Not Substantiated
- Inconclusive based on the following information:

Click Here and Type

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the Individual(s) and/or Facility is responsible for the

Abuse Neglect Financial Exploitation. This determination was based on the following:

The agency provided training to staff with orientation and at least annually thereafter regarding the vulnerable adult act including financial exploitation. The AP received the education and information about the client's rights.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484) – Compliance Met

The facility was found to be in compliance with Federal Regulations for HHA (Home Health Agencies) (42

CFR, Part 484). No deficiencies were issued.

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) – Compliance Met
The facility was found to be in compliance with State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Met

The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

Care Guide

Facility Name: Accra Home Health Duluth

Report Number: H8002003

Facility Incident Reports

Service Plan

Other pertinent medical records:

Police Report

Additional facility records:

Staff Time Sheets, Schedules, etc.

Facility Internal Investigation Reports

Personnel Records/Background Check, etc.

Facility Policies and Procedures

Number of additional resident(s) reviewed: None

Were residents selected based on the allegation(s)? Yes No N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

Yes No N/A

Specify: The agency to continued to provide home care services for the client

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) Yes No N/A

Specify: Facility self-report

If unable to contact complainant, attempts were made on:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

Interview with family: Yes No N/A Specify: Client preferred investigator not contact famil

Did you interview the resident(s) identified in allegation:

Yes No N/A Specify: _____

Did you interview additional residents? Yes No

Total number of resident interviews: None

Interview with staff: Yes No N/A Specify: _____

Tennessee Warnings

Tennessee Warning given as required: Yes No

Total number of staff interviews: Two

Physician Interviewed: Yes No

Facility Name: Accra Home Health Duluth

Report Number: H8002003

Nurse Practitioner Interviewed: Yes No

Physician Assistant Interviewed: Yes No

Interview with Alleged Perpetrator(s): Yes No N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:
_____	_____	_____	_____	_____	_____

If unable to contact was subpoena issued: Yes, date subpoena was issued _____ No

Were contacts made with any of the following:

Emergency Personnel Police Officers Medical Examiner Other: Specify _____

Observations were conducted related to:

Was any involved equipment inspected: Yes No N/A

Was equipment being operated in safe manner: Yes No N/A

Were photographs taken: Yes No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

The Office of Ombudsman for Long-Term Care

Duluth Police Department

Saint Louis County Attorney

Duluth City Attorney

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/28/2016
NAME OF PROVIDER OR SUPPLIER ACCRA HOME HEALTH DULUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5322 GRAND AVENUE DULUTH, MN 55807		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	INITIAL COMMENTS A complaint investigation was initiated to investigate case #H8002003. Accra Home Health Duluth was found to be in compliance with 42 CFR, Part 484, requirements for Home Health Agencies.	G 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H03338	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/28/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ACCRA HOME HEALTH DULUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 5322 GRAND AVENUE DULUTH, MN 55807
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>HOME CARE PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>On 2/11/2016, a complaint investigation was initiated to investigate complaint #H8002003. As a result of the investigation, the following correction order is issued.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)</p>	
0 325 SS=D	<p>144A.44, Subd. 1(14) Free From Maltreatment</p> <p>Subdivision 1. Statement of rights. A person who receives home care services has these rights:</p>	0 325		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H03338	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/28/2016
NAME OF PROVIDER OR SUPPLIER ACCRA HOME HEALTH DULUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5322 GRAND AVENUE DULUTH, MN 55807		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 325	<p>Continued From page 1</p> <p>(14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;</p> <p>This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure that one of one clients reviewed, (C1) was free from maltreatment when an employee financially exploited the client by taking \$53.00 from the client without the client's permission.</p> <p>This resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally.)</p> <p>Findings include:</p> <p>Review of C1's homemaker care plan dated 4/8/2015, established the licensee provided homemaking services to C1 in his/her own apartment. Homemaking services included providing transportation for the client for errands. C1 was capable of making her own decisions and directing her own care. C1 used a walker to assist with ambulation.</p> <p>Review of the police report dated 12/4/2016, established homemaker (HMK)-A was witnessed removing a white envelope from a bag attached to C1's walker and putting that envelope in the</p>	0 325		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H03338	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/28/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ACCRA HOME HEALTH DULUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 5322 GRAND AVENUE DULUTH, MN 55807
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 325	<p>Continued From page 2</p> <p>HMK-A's coat pocket. C1 identified HMK-A as the staff person that assisted her the day the money was missing from the walker. In addition, C1 said the envelope viewed being placed in HMK-A's coat pocket was the same envelope that contained C1's money. HMK-A was charged with theft.</p> <p>Interview with management staff of the licensee on 2/11/2016, at 1:33 p.m. established she was notified by the police of the alleged financial exploitation. HMK-A contacted the licensee after HMK-A had been notified by the police of the financial exploitation. HMK-A said she discovered the envelope in the backseat of her car the following day stating the envelope must have fallen out of C1's bag attached to the walker. Management staff told HMK-A a video from C1's hallway clearly showed HMK-A removing the envelope from C1's walker and placing the envelope in her coat pocket. HMK-A brought in a sealed envelope to the licensee indicating it contained C1's money. The licensee returned the money to police without opening the envelope.</p> <p>Interview with HMK-A on 2/11/2016, at 2:58 p.m. established she denied taking the money from C1 stating the envelope must have fallen out of the bag attached to C1's walker during transport. C1 sat in the passenger side of the car and HMK-A placed the walker in the backseat behind C1. HMK-A said she found the envelope the following day after being contacted by the police. HMK-A said the video showed her checking the bag attached to the walker in the hallway of C1's apartment to put C1's shoes that were in the bag toward the bottom of the bag. HMK-A denied taking the envelope with the money.</p> <p>Interview with C1 on 2/12/2016, at 1:53 p.m.</p>	0 325		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H03338	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/28/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ACCRA HOME HEALTH DULUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 5322 GRAND AVENUE DULUTH, MN 55807
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 325	<p>Continued From page 3</p> <p>established the day of the incident it was the first time homemaker HMK-A provided services for C1. HMK-A provided transportation for C1 in the HMK-A's vehicle to a local drug store. C1 had an envelope with cash to pay for her purchases which totaled about \$27.00 leaving \$53.00 in the envelope. C1 placed the envelope in a bag attached to the walker. HMK-A assisted C1 into her apartment leaving the walker in hallway which was common practice for C1. After HMK-A left, C1 remembered the envelope with the cash was in the bag attached to the walker. C1 checked the bag and the envelope was gone. C1 called the drug store and the store's security tape showed C1 putting the envelope in the bag attached to the walker. C1 contacted the care taker of the apartment building. Video from a camera located in the hallway pointing toward C1's apartment clearly showed HMK-A removing the envelope from the bag and placing the envelope in HMK-A's coat pocket. C1 contacted the local police.</p> <p>Review of the licensee's policy and procedure titled Handling of Client's Finances and Property with a revision date of 1/1/2015, stated agency staff may not borrow a client's property.</p> <p>Review of the licensee's policy and procedure titled Abuse Prevention with a revision date of 1/1/2015, did not address financial exploitation of a client as a form of maltreatment.</p> <p>Review of the licensee's policy and procedure titled Vulnerable Client Policy with a revision date of 1/1/2015, did not specifically address financial exploitation of a client.</p> <p>Time Period For Correction: Twenty-one (21) days.</p>	0 325		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H03338	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/28/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ACCRA HOME HEALTH DULUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 5322 GRAND AVENUE DULUTH, MN 55807
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER H03338	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/8/2017
Y1	Y2	Y3
NAME OF FACILITY ACCRA HOME HEALTH DULUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5322 GRAND AVENUE DULUTH, MN 55807

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 00325	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 144A.44, Subd. 1(14)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	02/08/2017	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) AW/mm	DATE 02/13/2017	SIGNATURE OF SURVEYOR 20784	DATE 02/08/2017
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/28/2016		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		